Save Print Reset

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

APPLICATION FOR PARENTERAL MODERATE SEDATION PERMIT

FEE: $100

PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK

MISSOURI DENTAL BOARD
3605 MISSOURI BOULEVARD
P.O. BOX 1367
JEFFERSON CITY MO 65102-1367
TELEPHONE: (573) 751-0040
TTY: (800) 735-2966

SECTION I – APPLICANT DATA

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)		LICENSE NUMBER
DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY NUMBER
HOME TELEPHONE NUMBER	BUSINESS TELEPHONE NUMBER	FAX NUMBER
MAILING ADDRESS		
CITY	STATE	ZIP CODE

SECTION II – EDUCATION AND TRAINING

1. I have completed a postgraduate program that is a minimum of twelve (12) continuous months in length and is approved or accredited to teach postgraduate dental or medical education by one of the following:

   ☐ a) the American Dental Association (ADA);
   ☐ b) the Accreditation Council for Graduate Medical Education of the American Association (AMA); or
   ☐ c) the Education Committee of the American Osteopathic Association (AOA);

   ☐ Yes ☐ No

2. My education and training in this program included:

   ☐ a) Sixty (60) hours of didactic training in pain and anxiety control and related subjects in accordance with the guidelines of the American Dental Association;
   ☐ b) Successful management of parenteral moderate sedation in twenty (20) dental patients. Management of parenteral moderate sedation shall be defined as performing and responsible for all aspects of the sedation procedure from patient selection to patient discharge post sedation for each of the twenty (20) dental patients.
   ☐ c) General anesthesia training in which there is four (4) weeks documented operating room clinical experience in airway management;

   ☐ Yes ☐ No

3. I am aware that each Dentist possessing a permit to administer parenteral moderate sedation shall maintain current certification in Advanced Cardiac Life Support (ACLS) at all times the sedation permit is active. I currently hold an active certification in Advanced Cardiac Life Support (ACLS).

   ☐ Yes ☐ No

Please attach the appropriate documentation of your education and training with this application. Applicants must have their postgraduate program director complete the "Verification of Parenteral Moderate Sedation Requirements" form. You must attach documentation of your current Advanced Cardiac Life Support (ACLS).

SECTION III – LOCATION(S) WHERE CONSCIOUS SEDATION SERVICES ARE PROVIDED.

Please list below the locations of the dental office(s) at which you intend to offer parenteral moderate sedation services. Please understand that pursuant to 20 CSR 2110-4.020, the dentist-in-charge of each of the following dental offices must secure a site certificate. A separate permit is required for each dental office.

You are required to successfully complete an on-site evaluation by consultants appointed by the Board. On-site evaluations will be conducted in accordance with 20 CSR 2110-4.030.

BUSINESS NAME	ADDRESS	CITY	STATE	ZIP CODE	SITE CERTIFICATE NO.
BUSINESS NAME	ADDRESS	CITY	STATE	ZIP CODE	SITE CERTIFICATE NO.
BUSINESS NAME	ADDRESS	CITY	STATE	ZIP CODE	SITE CERTIFICATE NO.
BUSINESS NAME	ADDRESS	CITY	STATE	ZIP CODE	SITE CERTIFICATE NO.
BUSINESS NAME	ADDRESS	CITY	STATE	ZIP CODE	SITE CERTIFICATE NO.

SECTION IV– NOTE: IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW, ATTACH A FULL EXPLANATION.

	YES	NO
1. Do you now or have you ever held any professional license, other than dentistry, in any state or country? If yes, indicate profession, license number and whether active or inactive.	☐	☐
2. Have you ever been suspended from practice, reprimanded, censured, or otherwise disciplined or disqualified as a dentist or a member of any profession? If so, provide the dates, facts and disposition of the matter and name and address of the authority in possession of the record thereof.	☐	☐
3. Have you ever voluntarily surrendered a professional license, including but not limited to a dental license, issued to you by any state or country?	☐	☐
4. Are charges or an investigation currently pending relative to your dental license in any state or country?	☐	☐
5. Has your employment, medical staff appointment or admitting or clinical privileges ever been denied, reduced, suspended, revoked or not renewed at any hospital, nursing home, clinic or other health care facility or are such actions currently pending?	☐	☐
6. Have you ever been suspended, sanctioned or otherwise restricted from participation in any private, federal or state health insurance program, i.e., Medicare or Medicaid, or are such actions currently pending?	☐	☐
7. Have you ever been denied a narcotic license or has your narcotic license ever been placed on probation, suspended, voluntarily surrendered or revoked or are such actions currently pending?	☐	☐
8. Have you ever been charged with or been convicted, adjudged guilty by a court, pled guilty or nolo contendere to any crime, whether or not sentence was imposed (excluding traffic violations)?	☐	☐
9. Are there any malpractice judgements against you resulting from the practice of dentistry?	☐	☐
10. Have you been adjudged insane or incompetent by a state or federal court within the past five years?	☐	☐
11. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed?	☐	☐
12. Are you now or have you been within the past five years, addicted to or dependent upon any illegal or prescription drugs, controlled substances or alcohol?	☐	☐

SWORN AFFIDAVIT

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the proceeding application for a Parenteral Moderate Sedation permit in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit for consideration, this application as required by the Missouri law governing the practice of dentistry and subject to the rules and regulations of the Missouri Dental Board. I subscribe and agree to abide by all applicable laws and rules regarding the practice of dentistry. I hereby certify that I have familiarized myself with Chapter 332, RSMo, known as the Dental Practice Act and applicable rules promulgated by the Missouri Dental Board.

Enclosed is the permit fee which is nonrefundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

MUST BE SIGNED IN PRESENCE OF NOTARY ▸	SIGNATURE OF APPLICANT	
NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	